STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 11F-07360

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 13 Hillsborough
UNIT: HMO

FILED
Dec 27 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 1, 2011, at 10:03 a.m.

## APPEARANCES

For the Petitioner: [redacted], the petitioner's mother

For the Respondent: [redacted], Medicaid health care program analyst

## ISSUE

The petitioner is requesting that either the petitioner's HMO, [redacted], pay for Independent Living Therapy Services to provide speech therapy for the petitioner at his private school, or disenroll the petitioner from the [redacted] plan, and enroll the petitioner in a different plan.

## PRELIMINARY STATEMENT

By notice dated September 2, 2011, the respondent informed the petitioner that his request for disenrollment with [redacted] was denied. On September 13, 2011, the petitioner timely requested a hearing.

The petitioner's representative and the respondent's representative appeared telephonically. Witness for respondent that appeared telephonically was [redacted], assistant vice president of quality control for [redacted]. Observing via telephone from AHCA were [redacted], specialist; [redacted], Medicaid health care program analyst; [redacted] Medicaid review monitor, and [redacted], Medicaid health care program analyst. Observing via telephone from [redacted] were [redacted] regulatory services manager, and [redacted], manager of quality management;

Petitioner presented seven exhibits which were accepted into evidence and marked as Petitioner Exhibits "1" through "7" respectively. Respondent presented one exhibit which was accepted into evidence and marked as Respondent Exhibit "1". The record was left open for 10 days for additional evidence. On November 1, 2011, the respondent submitted the [redacted] packet of evidence and Section 1932 from the Balanced Budget Act 1997. The [redacted] packet of evidence was entered into record as Respondent Exhibit 2 and Administrative Notice was taken of Section 1932 from the Balanced Budget Act 1997. The petitioner was given until November 14, 2011 to submit any response to the respondent's evidence. On November 9, 2011, the petitioner notified the hearing officer that she received the respondent's evidence and

was in agreement the evidence provided. The record was closed on November 14, 2011.

## FINDINGS OF FACT

1. The petitioner is a four year old child. The petitioner attends private school, with a scholarship. The petitioner has been diagnosed with speech delay. The petitioner is Medicaid eligible. The petitioner's Medicaid benefits are provided through a Health Maintenance Organization (HMO), an organization that provides managed care. The petitioner's HMO provider is [redacted].

2. The petitioner was seeing [redacted] for speech therapy from July 14, 2011 until August 15, 2011. The petitioner is no longer seeing [redacted]. [redacted] is a contract provider with [redacted]

3. The petitioner was seeing speech therapist [redacted]. After the petitioner starting attending private school, [redacted] would not travel to the private school. The petitioner's mother alleged the petitioner received poor services from [redacted].

4. The petitioner's mother found a speech therapist that would travel to the petitioner's private school. The speech therapist is with Independent Living Therapy Services. Independent Living Therapy Service is a provider for United Healthcare and Medipass. [redacted] will not give prior authorization for Independent Living Therapy Service to provide speech therapy at the petitioner's private school, as Independent Living Therapy is not an [redacted] provider. Independent Living Therapy Service will not accept [redacted] patients.

5. On September 2, 2011, [redacted] received the petitioner's request to change plans outside of the petitioner's open enrollment period. The request was

denied. The reason stated was that the request did not meet a state-approved good cause reason to leave the petitioner's current health plan. The petitioner would be able to change plans beginning February 17, 2012.

6. The petitioner requested an administrative appeal on September 13, 2011. The petitioner requested that either [redacted] pay for Independent Living Therapy Services to provide speech therapy for the petitioner at his private school, or disenroll the petitioner from the [redacted] plan, and enroll the petitioner in a different plan.

7. On September 22, 2011, the petitioner filed a complaint that the petitioner was unable to obtain speech therapy services at his private school.

8. The private school which the petitioner attends has an in-house speech therapist. The therapy services at the private school are provided for student for a cash fee. The therapist at the private school is not a contract provider with [redacted]. [redacted] contacted the speech therapist at the private school. [redacted] offered the speech therapist at the private school the option to submit prior authorization for service under consideration and complete Single Case Agreement of the services request. The therapist at the private school did not want to participate as an [redacted] provider. As the speech therapist at the private school did not want to participate as an [redacted] provider, [redacted] did not give prior authorization for speech therapy service to be paid to the speech therapist at the private school.

10. [redacted] provided the petitioner with a list of 29 participating speech therapist in petitioner's area. [redacted] informed the petitioner as follows. If the petitioner wants speech therapy from a speech therapist that is not an [redacted] provider, that speech therapist would need to submit prior authorization for service

under consideration and complete Single Case Agreement of the services request, or the petitioner would need to directly pay that speech therapist.

11. On September 23, 2011, the petitioner filed a grievance through the [redacted] grievance process.

12. [redacted] assistant vice president asserted that authorization for speech therapy would be given for speech therapist who was a provider in the [redacted] plan. [redacted] attempted to negotiate with the speech therapist at the petitioner's private school. The speech therapist at the petitioner's private school declined. As the petitioner's chose a new speech therapist and the new speech therapist was not a provider in the [redacted] plan, [redacted] could not authorize payment. [redacted] attempted to contract with the new speech therapist. The new speech therapist did not want to enter into a contract to be a provider in the [redacted] plan. The petitioner's next period of open enrollment starts February 2012. During that open enrollment, the petitioner may disenroll from [redacted].

## CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

14. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

15. The petitioner requested that either [redacted] pay for Independent Living Therapy Services to provide speech therapy for the petitioner at his private school, or

disenroll the petitioner from the [redacted] plan, and enroll the petitioner in a different plan. In accordance with Fla. Admin. Code § 65-2.060(1), the burden of proof was assigned to the petitioner.

A. As to the issue of [redacted] authorizing payment for speech therapy from a provider that is not in a participating provider with [redacted]:

16. The Florida Statutes § 409.912 states in regards to the agency contracting with HMO's:

> Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program.
> (3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.

17. The Florida Medicaid Provider General Handbook at page 1-28 describes Health Maintenance Organizations (HMOs):

> Description
> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

18. The Florida Medicaid Provider General Handbook at page 1-31 sets forth exemptions from HMO authorization:

> Exemptions from HMO Authorization

> All services must be prior authorized by the HMO plan except for the following:
> Emergency services;
> Family planning services regardless of whether the provider is a plan provider;
> The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments;
> OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services);
> Chiropractic, podiatry, and some dermatology services (the recipient must use a plan provider for these services); and
> Immunizations by county health departments.

19. The handbook does not indicate that the service speech therapy is exempt from prior authorization by the HMO.

B. As to the issue of disenrolling the petitioner from the [redacted] plan, and enrolling the petitioner in a different plan, outside of the open enrollment period.

20. The Florida Statutes at §409.969, Enrollment; disenrollment, state:

> (1) ENROLLMENT.—All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted under this part. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans.
> (2) DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. For purposes of this section, the term "good cause" includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may require a recipient to use the plan's grievance process before the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged.
> (a) The managed care plan internal grievance process, when used, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If

the result of the grievance process is approval of an enrollee's request to disenroll, the agency is not required to make a determination in the case.
(b) The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that good cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.
(c) Medicaid recipients enrolled in a managed care plan after the 90-day period shall remain in the plan for the remainder of the 12-month period. After 12 months, the recipient may select another plan. However, nothing shall prevent a Medicaid recipient from changing providers within the plan during that period.

21. The Florida Administrative Code at §59G-8.600 "Good Cause for Disenrollment from Health Plans" states:

(1) Recipients subject to the 12-month enrollment period may request disenrollment from the health plan for cause at any time during their no-change period. The no change period is defined as the period of time during which a recipient cannot change plans without a good cause reason in accordance with 42 CFR 438.56(c). Recipients making such requests must submit the request to the call center representative for a determination.
(2) Good Cause Reasons. The following reasons constitute good cause for disenrollment from the health plan:
(a) The recipient moves out of the county, or the recipient's address is incorrect and the recipient does not live in a county, where the health plan is authorized to provide services.
(b) The recipient is excluded from enrollment.
(c) A marketing violation occurred with the individual recipient that is substantiated by the Agency for Health Care Administration, Bureau of Managed Health Care. The recipient must submit the allegation in writing to the Bureau of Managed Care, 2727 Mahan Drive, M.S. 26, Tallahassee, FL 32308.
(d) The recipient is prevented from participating in the development of his treatment plan.
(e) The recipient has an active relationship with a health care provider who is not on the health plan's network, but is in the network of another health plan; or the health care provider with whom the recipient has an active relationship is no longer with the health plan.
(f) The recipient is ineligible for enrollment in the health plan.

(g) The health plan no longer participates in the county in which the recipient resides.
(h) The recipient needs related services to be performed concurrently, but not all related services are available within the health plan network; or the recipient's primary care provider (PCP) has determined that receiving the services separately would subject the recipient to unnecessary risk.
(i) The health plan does not, because of moral or religious objections, cover the service the recipient seeks.
(j) Poor quality of care.
(k) Lack of access to services covered under the contract, including lack of access to medically-necessary specialty services.
(l) The health plan makes inordinate or inappropriate changes of the recipient's primary care provider (PCP).
(m) An unreasonable delay or denial of service.
(n) Service access impairments due to significant changes in the geographic location of services.
(o) There is a lack of access to health plan providers experienced in dealing with the recipient's health care needs.
(p) Fraudulent enrollment.
(q) The recipient, although otherwise locked in, requests enrollment in a specialty plan and meets the eligibility requirements for the specialty plan.
(r) The recipient received a notice from their plan of a reduction in required benefits at the end of the plan's annual contract year (for the next year).

22. Member Handbook [redacted] Florida Medicaid/MediKids Program at page 35 sets forth for enrollment lock-in and disenrollment:

Enrollment Lock-In

Enrollment:
If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in [redacted] or the state enrolls you in a health plan, you will have 90 days from the date of your first enrollment to try the plan. During the first 90 days you can change health plans for any reason. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine months. This is called lock-in.

Open Enrollment:
If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called open enrollment. You do not have to change plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked

into that plan for the next 12 months. Every year you can change health plans during your 60-day open enrollment period.

Disenrolling from [redacted]
If you are a mandatory enrollee and you want to change plans after the initial 90-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change health plans:
You move out of the county, or your address is incorrect and you don't live in a county where Amerigroup is authorized to provide services
Your provider is no longer with the Amerigroup
You are excluded from enrollment
A substantiated marketing or community outreach violation has occurred
You are prevented from participating in the development of your treatment plan
You have an active relationship with a provider who is not on the Amerigroup panel but is on the panel of another health plan
You are in the wrong health plan as determined by AHCA
Amerigroup no longer participates in the county
The state has imposed intermediate sanctions upon Amerigroup (this is explained in 42 CFR 438.702(a)(3) in the Code of Federal Regulations)
You need related services to be performed concurrently, but not all related services are available within the Amerigroup network; or your PCP has determined that receiving the services separately would subject you to unnecessary risk Amerigroup does not, because of moral or religious objections, cover the service you seek
You missed open enrollment due to a temporary loss of eligibility for 60 days
Other reasons per 42 CFR 438.56(d)(2), including, but not limited to:
− Poor quality of care
− Lack of access to services covered under the contract
− Inordinate or inappropriate changes of PCPs
− Service access impairments due to significant changes in the geographic location of services
− Lack of access to providers experienced in dealing with your health care needs
− Fraudulent enrollment
Voluntary enrollees may disenroll from the plan at anytime
Some Medicaid recipients can change health plans whenever they choose, for any reason. For example, people who are eligible for both Medicaid and Medicare benefits and children who receive SSI benefits can change plans at any time for any reason...

23. The petitioner not a voluntary enrollee. The petitioner's next date of open enrollment starts February 17, 2012. The statute and rule set forth that no further changes may be made during the enrollment period except for good cause. The reasons for good cause include poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The petitioner's mother did allege poor quality of care from one provider. However, [redacted] provided the petitioner with 29 other speech therapy providers to choose from. [redacted] did not deny service. They denied payment for a speech therapy provider that was not an [redacted] provider. There was no evidence present that the petitioner enrollment was fraudulent. Therefore, the petitioner has not met his burden of proof that good cause was met. As the statute sets forth that no further changes may be made except for good cause and good cause was not met, the petitioner's request to disenroll from the Amerigroup plan is not within the rules and regulations of the Program.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this _____ day of _____, 2011,

in Tallahassee, Florida.

_____
Linda Jo Nicholson
Hearing Officer
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Copies Furnished To: [redacted], Petitioner
[redacted], Area 6 Medicaid Field Manager